Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHEAST METHODIST HOSPITAL
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3916

Respondent Name
Federal Insurance Co

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-09-B016-01

MFDR Date Received
August 3, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case."

Amount in Dispute: $29,722.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, Respondent requests a dismissal of this case in accordance with DWC Rule 133.307(e)(3)(F) as medical bill in question was reimbursed pursuant to a private contractual fee arrangement."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2008	Outpatient Hospital Services	$29,722.07	$4,965.11

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 8, 2008
   - 500 Reimbursement amount based on U&C allowance
   - B15 Procedure/Service is not paid separately
   - TC Technical Component
   - W1 Workers' Compensation State Fee Schedule Adj.

   Explanation of benefits dated October 1, 2008
   - B15 Procedure/Service is not paid separately
   - TC Technical Component
   - W1 Workers' Compensation State Fee Schedule Adj
   - W4 No additional payment allowed after review

   Explanation of benefits dated, November 20, 2008
   - B15 Procedure/Service is not paid separately
   - ORC See Additional Information
   - TC Technical Component
   - W1 Workers' Compensation State Fee Schedule Adj.
   - W3 Additional payment on appeal/reconsideration
   - W4 No additional payment allowed after review

   Explanation of benefits dated April 7, 2009
   - 168 No additional allowance recommended
   - 527 Recommended at 110% of invoice price
   - B15 Procedure/Service is not paid separately
   - ORC See Additional Information
   - RD7 Multiple Procedure/1st Procedure
   - TC Technical Component
   - W1 Workers' Compensation State Fee Schedule Adj
   - W3 Additional payment on appeal/reconsideration
   - W4 No additional payment allowed after review

   Explanation of benefits dated July 31, 2009
   - 168 No additional allowance recommended
   - 352 Network disc not applicable to procedure billed
   - 45 Contract/Legislated Fee Arrangement Exceeded
   - 527 Recommended at 110% of invoice price
   - 97 Charge Included in another Charge or Service
   - R95 Procedure Billing Restricted/See Medicare LCD
   - RD7 Multiple Procedure/1st Procedure
   - TC Technical Component
   - W1 Workers' Compensation State Fee Schedule Adj
   - W3 Additional payment on appeal/reconsideration
   - W4 No additional payment allowed after review

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Contract/Legislated Fee Arrangement Exceeded." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 14, 2010, the Division requested the respondent to provide a copy of the referenced

contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that a contractual fee arrangement is not supported with regard to the services in dispute. The respondent did not submit a complete copy of the alleged contract. The insurance carrier is not listed as a party to the alleged contract. The respondent did not submit information to support that the insurance carrier had been granted access to the alleged network agreement during the time period in which the disputed services were rendered. No documentation was found to support notification to the healthcare provider that the insurance carrier had been given access to the healthcare provider's contractual fee arrangement with the alleged network in the time and manner required by §133.4. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $75,042.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 85027, date of service August 4, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.04. 125% of this amount is $11.30. The recommended payment is $11.30.

   - Procedure code 85610, date of service August 4, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.49. 125% of this amount is $6.86. The recommended payment is $6.86.

   - Procedure code 85730, date of service August 4, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.38. 125% of this amount is $10.48. The recommended payment is $10.48.

- Procedure code 88300, date of service August 4, 2008, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 433, which, per OPPS Addendum A, has a payment rate of $15.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $9.16. This amount multiplied by the annual wage index for this facility of 0.8896 yields an adjusted labor-related amount of $8.15. The non-labor related portion is 40% of the APC rate or $6.11. The sum of the labor and non-labor related amounts is $14.26. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $14.26. This amount multiplied by 130% yields a MAR of $18.54.
- Procedure code 72020, date of service August 4, 2008, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.8896 yields an adjusted labor-related amount of $23.64. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $41.36. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $41.36. This amount multiplied by 130% yields a MAR of $53.77.
- Procedure code 71010, date of service August 4, 2008, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.8896 yields an adjusted labor-related amount of $23.64. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $41.36. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $41.36. This amount multiplied by 130% yields a MAR of $53.77.
- Procedure code 63650, date of service August 4, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 40, which, per OPPS Addendum A, has a payment rate of $4,062.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,437.69. This amount multiplied by the annual wage index for this facility of 0.8896 yields an adjusted labor-related amount of $2,168.57. The non-labor related portion is 40% of the APC rate or $1,625.13. The sum of the labor and non-labor related amounts is $3,793.70. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $3,793.70. This amount multiplied by 130% yields a MAR of $4,931.81.
- Procedure code 63650, date of service August 4, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 40, which, per OPPS Addendum A, has a payment rate of $4,062.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,437.69. This amount multiplied by the annual wage index for this facility of 0.8896 yields an adjusted labor-related amount of $2,168.57. The non-labor related portion is 40% of the APC rate or $1,625.13. The sum of the labor and non-labor related amounts is $3,793.70. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $3,793.70. This amount multiplied by 130% yields a MAR of $4,931.81.
- Per Medicare policy, procedure code 93005, date of service August 4, 2008, may not be reported with procedure code 63650 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 95972, date of service August 4, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 663, which, per OPPS Addendum A, has a payment rate of $97.53. This amount multiplied by 60% yields an unadjusted labor-related amount of $58.52. This amount multiplied by the annual wage index for this facility of 0.8896 yields an adjusted labor-related amount of $52.06. The non-labor related portion is 40% of the APC rate or $39.01. The sum of the labor and non-labor related amounts is $91.07. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $91.07. This amount multiplied by 130% yields a MAR of $118.39.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the

separate implantables include:

- "RESTORE RECHARGER" as identified in the itemized statement with a cost per unit of $1,995.00;
- "GENERATOR RESTORE 3771" as identified in the itemized statement with a cost per unit of $16,900.00;
- "RESTORE ANTENA PROGRA" as identified in the itemized statement with a cost per unit of $80.00;
- "KIT LEAD 1X8 COMP 3778" as identified in the itemized statement with a cost per unit of $1,995.00;
- "EXTENSION LEAD MED 370" as identified in the itemized statement with a cost per unit of $645.00 at 2 units, for a total cost of $1,290.00;
- "PROGRAMMER RESTORE ULT" as identified in the itemized statement with a cost per unit of $1,100.00.

5. The total allowable reimbursement for the services in dispute is $35,142.73. This amount less the amount previously paid by the insurance carrier of $30,177.62 leaves an amount due to the requestor of $4,965.11. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,965.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,965.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 13, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.